

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 JANICE K. LACHMAN
Supervising Deputy Attorney General
3 KENT D. HARRIS, State Bar No. 144804
Deputy Attorney General
4 1300 I Street, Suite 125
P.O. Box 944255
5 Sacramento, CA 94244-2550
Telephone: (916) 324-7859
6 Facsimile: (916) 327-8643

7 Attorneys for Complainant

8
9 **BEFORE THE**
10 **BOARD OF REGISTERED NURSING**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12 In the Matter of the Accusation Against:

Case No. 2008-352

13 NEHEMIAH QUIPOT,
a.k.a. NEHEMIAH RAMIREZ QUIPOT
14 8564 Culpepper Drive
Sacramento, CA 95823

A C C U S A T I O N

15 Registered Nurse License No. 411793

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in
21 her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department
22 of Consumer Affairs.

23 2. On or about March 31, 1987, the Board issued Registered Nurse License
24 Number 411793 to Nehemiah Quipot, also known as Nehemiah Ramirez Quipot ("Respondent").
25 Respondent's registered nurse license was in full force and effect at all times relevant to the charges
26 brought herein and will expire on October 31, 2008, unless renewed.

27 ///

28 ///

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

2

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 8. In or about September 2006, Resident A was admitted to Bruceville
4 Terrace, a skilled nursing facility located in Sacramento, California, with a diagnosis of end stage
5 COPD.

6 9. On October 17, 2006, the resident's wife was attempting to feed him
7 lunch. Resident A started choking and the nursing staff asked her to stop as the resident was
8 unable to swallow any longer. Resident A's physician was notified of the resident's change in
9 condition. At 1200 hours that same day, the physician ordered IV morphine sulfate for the
10 resident as follows: "Morphine Sulfate 100 mg/100 ml NS IV drip, Begin @ 1mg/hr, may titrate
11 by 1 mg Q hr. PRN Resp. Distress, comfort, max of 10 mg/hr."

12 10. M. S. was the medication nurse caring for Resident A. M. S. retrieved the
13 necessary equipment to start the IV morphine. On her way to the resident's room, M. S. told
14 Respondent that she had experience managing an infusion pump with IV antibiotics; however,
15 she was not familiar with setting the rate on the IV pump and requested Respondent's help in
16 checking the infusion pump for the correct rate of fusion. Respondent instructed M. S. to set the
17 infusion pump at *100 ml per hour* or to use number code 100/100. At 1230 hours, M. S. set the
18 pump and started the infusion as Respondent had suggested and asked Respondent to check the
19 pump and the setting. Respondent checked the settings on the pump, and without looking at the
20 medication bag, gave M. S. a "thumbs-up", indicating that the pump was set appropriately. At
21 1330 hours, M. S. checked on the resident and discovered that the medication bag was totally
22 infused and empty. M. S. retrieved a second IV morphine sulfate infusion bag from the
23 medication room refrigerator and hung it on the resident's infusion pump at a rate of *100 mg per*
24 *hour*. After a few minutes, M. S. felt that the rate was too fast and decreased the rate to 20 ml
25 per hour. At 1430 hours, M. S. and another nurse went to the resident's room to assess him and
26 found the resident without a pulse or respirations.

27 ///

28 ///

11. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 17, 2006, while employed as a registered nurse at Bruceville Terrace, Sacramento, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as follows: Respondent failed to check the correct medication and dose when checking the rate of infusion of the IV morphine to be administered to Resident A. When asked by M. S. to check the infusion pump for the correct rate of fusion, Respondent checked the pump, but failed to check the medication being infused, and gave M. S. a "thumbs up", indicating that the rate was correct. Further, Respondent assumed the medication to be infused was an antibiotic. As a result of Respondent's acts or omissions, the resident received over approximately 150 times the prescribed morphine in a two hour period.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 8 through 10 above.

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about October 17, 2006, while employed as a registered nurse at Bruceville Terrace, Sacramento, California, Respondent committed acts constituting unprofessional conduct, as set forth in paragraph 11 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 411793, issued to Nehemiah Quipot, also known as Nehemiah Ramirez Quipot;

2. Ordering Nehemiah Quipot, also known as Nehemiah Ramirez Quipot; to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/16/08.



RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant